AMERICA'S AFFORDABLE HEALTH CHOICES ACT

# QUALITY AFFORDABLE HEALTH CARE

## What Will Health Care Reform Do for You?

*If you have insurance...*

- Lets you keep your plan if you like it.
- Puts you and your doctor – not your insurance company – in charge of your medical decisions.
- Prevents insurance companies from dropping you because you get "too sick."
- Gives you peace of mind that you won't lose coverage if you lose your job, move or change jobs.
- Limits the out-of-pocket expenses your insurance company can make you pay.
- Covers preventive care with no copays or deductibles.
- Keeps your insurance company from denying you coverage – or charging more – because you've had diabetes, heart disease or any other pre-existing condition.

*If you don't have insurance...*

- You can choose a quality, affordable health plan through the health insurance exchange marketplace:
  - Offers low group rates even for individual coverage.
  - Promotes choice, competition and transparency.
  - Includes a public health insurance option competing on a level playing field with private insurers.
  - No insurance company can deny you coverage because you have had heart disease, diabetes or another pre-existing condition.

*What's in it for seniors...*

- Begins to close the Medicare Part D donut hole to save money on prescriptions.
- Eliminates cost-sharing for preventive care
- Extends solvency of Medicare by at least 5 years.
- Strengthens access to your doctor and improves care.

Source: Office of the Speaker

**NOTE TO REPORTERS: VETERANS CONCERNS ADDRESSED IN HEALTH CARE LEGISLATION**
**From: Press Office of Energy and Commerce Committee**

**Date: Friday, July 31, 2009**

Several veterans' organization wrote to Speaker Pelosi yesterday raising concerns that H.R. 3200, America's Affordable Health Choices Act, would limit care to veterans. We are writing to say that these concerns are already addressed in the legislative language and with amendments accepted during our Committee's markup (Buyer).

Specifically, veterans' health care will not be impacted by the House legislation. Section 202 (d)2(E) and (F) of the bill states that "members of the armed forces and dependents (including TRICARE) and those who receive VA care will be considered as having acceptable minimum coverage – in other words, veterans will not subject to the 2.5% penalty if they are enrolled in TRICARE or VA care.

The Energy and Commerce Committee also accepted amendments by Rep. Steve Buyer (R-IN) during the markup of the legislation to further clarify that those who participate in the VA system will be exempt from the requirements of the legislation.

In addition, addressing another concern from the veterans' groups, family members of veterans who do not have health insurance coverage will be eligible to find appropriate coverage through the exchange, just as all other qualified Americans.

Finally, since TRICARE and VA care are exempted from our legislation, no other government agency will be able to infringe on the Secretary of Veterans Affairs' authority over the TRICARE program.

As this process moves forward, we look forward to working with these groups to ensure their concerns are properly addressed.

AMERICA'S AFFORDABLE HEALTH CHOICES ACT

# QUALITY AFFORDABLE HEALTH CARE

## THE TRUTH ABOUT SMALL BUSINESSES

Small businesses are among those who benefit most from America's Affordable Health Choices Act.

### WHY SMALL BUSINESSES NEED HELP

- **LESS THAN HALF INSURE WORKERS: Only 45 percent** of America's smallest firms can afford to offer health care benefits. In fact, **60% of America's uninsured – or 28 million—are small business owners, workers, and their families.**
- **COSTS GOING UP:** Insurance costs for small businesses have increased **129 percent since 2000.**
- **WORKERS PAY MORE:** Small business workers pay an average of **18% more in premiums** than those in large firms for the same benefits. Their **deductibles are more than double**.
- **HIGHER ADMINISTRATIVE COSTS: Up to 25 percent of the cost of premiums** for some small business health plans, compared to 10 percent for large firms.

### GIVING SMALL BUSINESSES ACCESS TO AFFORDABLE, RELIABLE COVERAGE

- **UNDER BILL, SMALL BUSINESSES CAN NOW BUY POLICIES THAT NO LONGER:**
  - ✓ Exclude coverage based on pre-existing conditions
  - ✓ Selectively refuse to renew coverage
  - ✓ Charge different premiums based on gender, occupation, or pre-existing conditions
  - ✓ Set unreasonable out-of-pocket spending limits that drive families deeply into debt
- **ADVANTAGES OF NEW HEALTH INSURANCE EXCHANGE FOR SMALL BUSINESSES**
  - ✓ Affordable large group rates
  - ✓ Stable pricing from year to year
  - ✓ Lower administrative costs
  - ✓ Choice of plans for employees
- **ACCESS OF SMALL BUSINESSES TO THE HEALTH INSURANCE EXCHANGE**
  - ✓ In first years, the Health Insurance Exchange is targeted to serve employees of small businesses and the uninsured

### TAX CREDITS TO HELP SMALL BUSINESSES PROVIDE COVERAGE

- **A PERMANENT TAX CREDIT FOR SMALL BUSINESSES** to help them offer coverage to their employees – which phases out as employers' size and average wages increase
- **TAX CREDITS OF UP TO 50% OF THE COSTS** of providing health insurance to their employees for small businesses with 25 or fewer employees and average wages of less than $40,000

### MOST SMALL BUSINESSES EXEMPT FROM SHARED RESPONSIBILITY REQUIREMENT

Just like auto insurance, everyone must be insured to make the system work. The bill is built on the concept of shared responsibility. Under the bill, individuals who are self-employed or unemployed would be required

to purchase a plan if they don't qualify for other insurance. Mid-sized and large businesses would be required to offer health coverage to their employees or pay an 8 percent payroll fee to help subsidize their coverage in the Exchange.

In recognition that providing health insurance is unaffordable for many small businesses, the bill exempts most small businesses from the shared responsibility requirement and subjects others to a lower rate. The following is a description of the provisions, as modified by the Blue Dog-Waxman agreement announced on July 29.

- **SMALL BUSINESSES GET EXEMPTIONS**
  - **Payrolls of $500,000 or below are completely exempt**
  - **Payrolls between $500,000 and $750,000 face a graduated fee if no coverage is provided**

96% OF SMALL BUSINESS OWNERS NOT SUBJECT TO HEALTH CARE SURCHARGE

Under the bill, the wealthiest 1.2% of Americans would pay a surcharge on income over certain levels to help make health insurance affordable for small businesses and the middle class. For small business owners, **the surcharge is only on net profits (or what you take out of the business)** —receipts minus expenditures (payroll, capital expenses, etc.)—**above $280,000 (for single filers) and $350,000 (for married filers).**

- **96% OF SMALL BUSINESSES PAY NOTHING**
  - The nonpartisan Joint Committee on Taxation estimates that only 4.1% of small business owners would net that much and therefore pay the surcharge, **using the broadest definition of a small business owner** (i.e., any individual with as little as $1 in small business income)

- **OF THE REMAINING 4%:**
  - **Half earn less than one-third of their income from small businesses** – not what we think of as truly "small business owners"
  - **Only 1.1% would pay the top rate** —among them, hedge fund managers, private equity fund managers, lawyers, and lobbyists making millions of dollars a year

AMERICA'S AFFORDABLE HEALTH CHOICES ACT

# QUALITY AFFORDABLE HEALTH CARE

## HEALTH REFORM AT A GLANCE:
## MEETING HEALTH CARE NEEDS OF SENIOR CITIZENS & PEOPLE WITH DISABILITIES

Medicare has been a stable, reliable program for senior citizens, people with disabilities and those with End Stage Renal Disease for over four decades and provides coverage for over 45 million individuals each year. Health reform is needed to rein in rising health costs for private and public programs alike. Improving and strengthening Medicare is a critical component of reform.

The House Democratic bill will improve Medicare beneficiaries' access to quality, affordable health care.

### MEDICARE PROVISIONS IN THE BILL:

- **Fills the Part D Drug Program Donut Hole:** Addresses one of seniors' top concerns by filling in the Medicare Part D donut hole which will make prescription drugs more affordable. Seniors will receive 50% discounts on brand-name drugs in the donut hole immediately. The donut hole is reduced by $500 in 2011 and it is completely filled over a number of years.
- **Enhances Preventive Coverage:** Eliminates copayments for preventive services in Medicare.
- **Helps Low-Income Seniors:** Improves low-income subsidy programs to help ensure Medicare is affordable for those with low and modest incomes.
- **Combats Waste, Fraud & Abuse:** Ensures the program operates in the best interests of its beneficiaries – and all taxpayers – by expanding authority to fight waste, fraud and abuse.
- **Ends Medicare Advantage Overpayments:** Ends overpayments to private health plans in Medicare, called Medicare Advantage plans, and adds additional consumer protections to ensure that these plans are investing premiums in patient care and do not charge higher cost-sharing than traditional Medicare.
- **Protecting the Doctor-Patient Relationship and Improving Quality:** Resolves a long-standing problem with the physician payment formula in a way that promotes primary care and advances innovation. Investments in health delivery system reform will improve coordinated care, promote efficiency, and enhance quality.
- **Extends the Medicare Trust Fund:** Following the advice of experts at the Medicare Payment Advisory Commission, the proposal makes numerous changes in provider payments that enhance the solvency of Medicare and put it on stronger financial footing for the future.

PREPARED BY THE HOUSE COMMITTEES ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR
AUGUST 7, 2009

# AN AMERICAN SOLUTION
# QUALITY AFFORDABLE HEALTH CARE

## HEALTH REFORM AT A GLANCE:
## PREVENTING DISEASE/ IMPROVING THE PUBLIC'S HEALTH

Increased access to treatment, while vitally necessary for fixing our broken health system, is only part of the answer. True reform requires prevention investments to reduce the strain that disease and poor health exert on our health care system. These investments are extremely cost-effective and beneficial, particularly as compared with treatment.

Preventive services can be divided into two general groups. Clinical preventive services are delivered to one patient at a time by a doctor or other health worker in a standard health setting. Community preventive services are delivered outside of this traditional clinical structure, and are frequently implemented across targeted groups.

| Examples of Preventive Services | |
|---|---|
| **Clinical Preventive Services** | **Community Preventive Services** |
| ▪ Cancer screenings (breast, cervical, colorectal, etc.)<br>▪ Daily aspirin use to prevent heart disease<br>▪ Adult and child immunizations<br>▪ Adult vision screening<br>▪ Hypertension treatment | ▪ Telephone "quit" lines to help smokers kick the habit<br>▪ Distribution of child safety seats<br>▪ Improving healthy food availability at worksites to reduce obesity<br>▪ Educating diabetics about blood sugar control (at churches, libraries, etc.) |

The bill's Prevention and Wellness provisions present a comprehensive policy designed to ensure that all Americans will receive the state-of-the-art in both clinical and community preventive services, undertaking a coordinated effort to make comprehensive prevention research, evaluation, and delivery a permanent part of the national landscape.

### PREVENTION AND WELLNESS:

- Expand the capacity of two independent, advisory task forces — the U.S. Preventive Services Task Force (USPSTF) and the Task Force on Community Preventive Services (TFCPS) — to undertake rigorous, systematic reviews of existing science to recommend the adoption of proven and effective services.
- Provide new investments in the science of prevention to further expand the base of information available for evaluation by the task forces.
- Deliver clinical preventive services by including USPSTF-recommended services in Medicaid and insurance available in the Health Insurance Exchange.
- Eliminate cost-sharing on recommended preventive services delivered by Medicare and insurance available in the Health Insurance Exchange.
- Deliver community preventive services by investing in state, territorial, and local public health infrastructure and by providing grants to implement TFCPS-recommended services.

PREPARED BY THE HOUSE COMMITTEES ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR
JULY 13, 2009

# Highlights of House Energy & Commerce Bill

## Improving Competition in the Insurance Market

- Creation of a Health Exchange where people who aren't covered by their employer can purchase health insurance plans
- Affordability credits (subsidies to buy coverage) available for families who earn up to 400% of the Federal poverty level
- Minimum level of protections guaranteed to prevent abuses by health insurance companies:
    - These apply to insurance plans in the Exchange and also the insurance you get through your employer
    - No discrimination for preexisting conditions
    - Yearly and life-time caps on out of pocket expenses for individuals
    - Minimum benefits that must be covered (will be determined by a Commission headed by the Surgeon General)
    - No discrimination on gender or health factors i.e. no higher rates for women just because they are women
    - No co-pays for preventive care

- Public Option
    - This is one option available to those who choose
    - Nobody will ever be forced to buy this option
    - Administered by Department of Health & Human Services
    - Must adhere to same rules as private companies
    - Self-financed through patients' premiums
    - One-time loan from the government for start-up costs and no additional federal funding to help support its function
    - Provides competition to private insurance companies in that there are no profit motives
    - Helps mitigate current monopolies that many plans have in most regions

## Improving the Quality of Care

- Ensures that all children have access to dental and vision benefits
- Greater emphasis on primary care – physicians will be better reimbursed for primary and preventive care; patients won't have any copays to access primary care
- Creates innovative community-based programs to focus on wellness and prevention
- Invests in health workforce to combat growing shortage of physicians, nurses and allied health professionals through loan repayment programs, scholarships
- Encourages training of primary care workforce through redistribution of residency slots and incentives to serve in currently underserved areas

*Prepared by the office of Congresswoman Lois Capps, August 2009*
*Sources: House Energy & Commerce Committee; Congressional Research Service (CRS); Kaiser Family Foundation*

## Improving Medicare

- Phased-in closure of Medicare "Doughnut Hole"
  - During the phase-in period, brand name drugs will be offered at 50% discount when Medicare beneficiaries fall in the "doughnut hole"
- Eliminates overpayments of Medicare Advantage – they should be able to provide care at the same rate as the rest of Medicare
- New payment incentives to decrease preventable hospital readmissions
- Restructures payment system so that it doesn't reward for each test and procedure, but rather quality and outcomes of care for an entire episode
- Corrects flawed system of calculating geographical differences in reimbursements in California
  - Specifically helps counties like Santa Barbara and San Luis Obispo where physicians are reimbursed as if they practice in low-cost, rural counties based on 40 year old data
  - Increases reimbursement rates in counties like Santa Barbara and San Luis Obispo, which will help attract new physicians and retain our current ones

## Assistance for Small Employers

- Payrolls under $500,000 are exempt from providing employees with coverage
- $500,000-$750,000 payroll size have sliding scale responsibility if they don't provide coverage for employees
- Tax credits to help small businesses offer coverage to their employees

*Prepared by the office of Congresswoman Lois Capps, August 2009*
*Sources: House Energy & Commerce Committee; Congressional Research Service (CRS); Kaiser Family Foundation*

# AN AMERICAN SOLUTION
# QUALITY AFFORDABLE HEALTH CARE

## HEALTH REFORM AT A GLANCE:
## INNOVATIVE DELIVERY SYSTEM REFORM

Reining in rising health costs and improving quality hinges on doctors, hospitals, and other providers working together to ensure they are providing the right care to the right patient at the right time. Rather than rewarding the *quantity* of care, payment systems must be modernized to reward high *quality* care. Realigning payment incentives will reduce overuse, slow the growth of health care costs, and improve Americans' health. America's Affordable Health Choices Act contains multiple provisions to reform the health care delivery system.

### PROMOTING ACCOUNTABLE CARE ORGANIZATIONS

An "accountable care organization" is an organized group of physicians who are rewarded for providing high quality care at low cost over a sustained period of time. Section 1301 directs the Secretary to establish a comprehensive ACO pilot program and authorizes the continued expansion of the program where it proves successful in improving quality and keeping costs under control.

### PROMOTING PAYMENT BUNDLING

Hospital and physician incentives can be restructured by paying a lump sum for an episode of care ("bundling" payments), rather than paying separately for each service provided. Section 1152 directs the Secretary to establish pilot programs to test the effectiveness of payment bundling across the nation in a wide array of formats so we can learn the best way to bundle payments to encourage efficiency and ensure quality.

### REDUCING HOSPITAL READMISSIONS

Section 1151 uses new financial incentives to encourage hospitals and post-acute providers to undertake reforms needed to reduce preventable readmissions, which will improve care for beneficiaries and rein in unnecessary health care spending.

### REWARDING HIGH-QUALITY AND EFFICIENT CARE

Section 1162 provides for increased payments to Medicare Advantage plans that demonstrate high quality of care and outcomes and plans that significantly improve quality.. Section 1123 increases Medicare rates by 5% in the areas of the country that provide the most efficient care.

### PROMOTING THE "MEDICAL HOME" MODEL

Section 1302 directs the Secretary to establish a pilot program to reward physicians and nurse practitioners who make their offices a "medical home" for patients by being fully available to patients and by ensuring that patient care is coordinated and comprehensive. The Secretary is authorized to expand the medical home concept if it proves effective in improving quality of care and holding down costs.

### PROMOTING "SHARED DECISIONMAKING"

There is evidence that providing patients with more information about the risk and benefits of treatment options can help keep health care costs down and ensures that patients are fully involved in the care they receive. Section 1235 directs the Secretary to establish a demonstration program to evaluate the benefits of having doctors spend more time consulting with their patients about various treatment options.

## PROMOTING PRIMARY CARE

Primary care providers can provide lower cost and higher quality care for many ailments. Section 1303 increases payment rates for primary care physicians by 5% and provides an additional 5% payment increase for primary care physicians in health shortage areas. Section 1121 provides for preferential updates for payment rates for primary care services in Medicare. Section 2212 expands scholarships and section 2211 creates a new loan repayment program to train more primary care physicians. Section 2201 builds on current expansions to the National Health Service Corps to get more physicians to health shortage areas, and this expansion in the Corps could eliminate 40% of the current estimated deficit in primary care providers. Sections 1501 and 1502 encourage more training of primary care medical residents and advance training in the outpatient setting, where most primary care is delivered.

## DISCLOSING FINANCIAL RELATIONSHIPS

Section 1451 reflects MedPAC recommendations that all manufacturers of drugs and devices should report their financial relationships with health entities, including physicians, pharmacies, hospitals, and other organizations. MedPAC has concluded that such relationships can create conflicts, which lead to increased spending and suboptimal patient care.

## UPDATED PAYMENT RATES

MedPAC has identified areas of overpayment to skilled nursing facilities, inpatient rehabilitation facilities, and home health care providers. Sections 1101, 1102, and 1154 adopt these payment changes to ensure we are spending taxpayer dollars appropriately. Sections 1103, 1131 and 1155 embrace the President's recommendation to adjust payments so that providers are encouraged to increased productivity in how they deliver health care.

## HEALTHCARE ASSOCIATED INFECTIONS

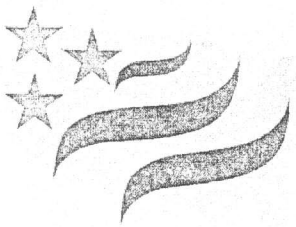
Section 1461 requires that hospitals and ambulatory surgical centers report public health information on healthcare associated infections to the Centers for Disease Control and Prevention. Section 1751 expands to Medicaid the current Medicare policy of denying payment for certain healthcare associated infections.

## MORE AND BETTER HEALTH CARE DATA

The transition to a more efficient, higher-quality health care system begins with getting more data about the clinical effectiveness of medical procedures. Section 1401 invests $2.9 billion in comparative effectiveness research. Sections 1124, and 1441, 1443, 1444 and 1145 expand physician and hospital reporting of quality measures. Section 2531 creates a registry to track the use of medical devices. Section 1442 directs the Secretary to develop improved measures of health care quality. Section 2402 creates the Assistant Secretary for Health Information to provide for ongoing monitoring and reporting on critical population health data.

## DEVELOPING NEW INNOVATIVE PRACTICES TO IMPROVE QUALITY

Measurement of quality is only useful if there are levers for change. Section 2401 creates the Center for Quality Improvement at the Agency for Healthcare Quality and Research in order to identify existing best practices, develop new best practices, and disseminate successful models around the country.



# AN AMERICAN SOLUTION QUALITY AFFORDABLE HEALTH CARE

## HEALTH REFORM AT A GLANCE:
## PROTECTING PROGRAM INTEGRITY BY PREVENTING WASTE, FRAUD AND ABUSE

Reducing waste, fraud, and abuse saves taxpayer dollars and protects the health care investments of individuals, businesses, and government. Under the bill, existing compliance and enforcement tools are strengthened for Medicare and Medicaid. In addition, the new public health insurance option and Health Insurance Exchange contain protections against waste and abuse that build upon the safeguards and best practices gleaned from experience in other areas.

### PROGRAM INTEGRITY:
### STRENGTHEN MEDICARE AND MEDICAID PROGRAM REQUIREMENTS FOR PROVIDERS, SUPPLIERS, AND CONTRACTORS

- Require providers and suppliers to adopt compliance programs as a condition for participating in Medicare and Medicaid.
- Require Medicare and Medicaid integrity contractors that carry out audits and payment review to provide annual reports and conduct regular evaluations of effectiveness.

### ADEQUATELY FUND EFFORTS TO FIGHT FRAUD AND AGGRESSIVELY MONITOR MEDICARE AND MEDICAID FOR EVIDENCE OF FRAUD, WASTE, AND ABUSE

- Increase funding for the Health Care Fraud and Abuse Control Fund to fight Medicare and Medicaid fraud. CBO has estimated that every $1 invested to fight fraud results in approximately $1.75 in savings.
- Create a comprehensive "Medicare and Medicaid Provider/Supplier" Data Bank, to enable oversight of suspect utilization and prescribing patterns and complex business arrangements that may conceal fraudulent activity.
- Narrow the window for submitting Medicare claims for payment in order to decrease the opportunities for "gaming" the system.

### IMPROVE SCREENING OF PROVIDERS AND SUPPLIERS

- Create a national pre-enrollment screening program to determine whether potential providers or suppliers have been excluded from other federal or state programs or have a revoked license in any state.
- Allow enhanced oversight periods or enrollment moratoria in program areas determined to pose a significant risk of fraudulent activity.
- Require that only Medicare-enrolled physicians can order durable medical equipment (DME) or home health services paid for by Medicare, and allow the Administrator of the Centers for Medicare and Medicaid Services to adopt similar requirements for other "at-risk" programs.

### NEW PENALTIES TO DETER FRAUD AND ABUSE

- Create new penalties for submitting false data on applications, false claims for payment, or for obstructing audits or investigations related to Medicare or Medicaid.
- Establish new penalties for Medicare Advantage and Part D plans that violate marketing regulations or submit false bids, rebate reports, or other submissions to CMS.

PREPARED BY THE HOUSE COMMITTEES ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUCATION AND LABOR
JULY 13, 2009

DEMOCRATIC CAUCUS
U.S. HOUSE OF REPRESENTATIVES
John B. Larson, Chairman
Xavier Becerra, Vice Chair

# Health Care Reform -- The Cost of Inaction

## The burden of health care in America now:

The rising cost of health care is straining the wallets of American families, the balance sheets of our businesses, and the long term health of our federal budget. Right now, America spends nearly 50% more per person on health care than any other country – and all that spending isn't making us any healthier.

- In the last decade the cost of health care for American families has skyrocketed -- premiums have doubled and deductibles and out-of-pocket expenses have gone up and up.

- The broken health care system will cost us as much as $248 billion in lost productivity this year alone.

- Providing health care for the uninsured costs insured American families $100 billion every year.

***The status quo is unsustainable*** -- Things will only get worse if we do nothing. Every American risks losing their health insurance and seeing their costs skyrocket unless we reform health care now.

## If we do nothing, the future of health care looks like this:

- ***Family budgets are stretched even further.***

  - The cost an employer-sponsored family health insurance plan reaches $24,000 by 2016 – an increase of 84%. That means most American households spend 45% of their income on health insurance.

  - Families are paying more for less as the average deductible increases 73% to almost $2,700 by 2016 and copayments go up.

  - More families face economic ruin because of illness as the number of uninsured Americans grows to 66 million by 2019. Middle class families are most likely to lose their coverage.

➢ ***American businesses fall behind.***

- Employer spending on health care premiums more than doubles to $885 billion in 2019 from $430 billion.

- As premiums increase 20%, expected in the next four years, 3.5 million workers lose their jobs.

- Because of rising costs, one in five employers stop offering health benefits in the next three to five years. 11 million Americans lose their employer-sponsored health insurance by 2019.

❖ ***The federal government goes broke.***

- As Americans lose their private insurance, many are added to already-strained government programs. Combined with the rising cost of care, spending on Medicare and Medicaid doubles from $720 billion in 2009 to $1.4 trillion in 2019.

- By 2017 the fund that pays for Medicare and Medicaid is broke and can't pay for benefits at the current level.

- Within a decade we spend one out of every $5 we earn on health care. In 30 years, we spend one out of every $3.

# America's Affordable Health Choices Act
# Implementation Timeline

## 2010

**ENDS HEALTH INSURANCE RESCISSIONS:** Prohibits abusive practices by health insurance companies rescinding existing health insurance policies as a way of avoiding covering the costs of enrollees' health needs.

**ENACTS ADMINISTRATIVE SIMPLIFICATION:** Begins adopting and implementing administrative simplification requirements to reduce paperwork, standardize transactions, and greatly reduce the administrative burdens and costs in today's health care system.

**CREATES REINSURANCE FOR EARLY RETIREES:** Creates a new temporary reinsurance program to help companies that provide early retiree health benefits for those ages 55-64 offset the expensive cost of that coverage.

**IMPLEMENTS PHYSICIAN PAYMENT REFORMS IN MEDICARE:** Averts a 20% pay cut for physician services that threatened Medicare beneficiaries' access to medical care. Implements physician payment reforms that enhance payment for primary care services and encourage physicians to join together to form "accountable care organizations" to gain efficiencies and improve quality.

**IMPROVES PREVENTIVE HEALTH COVERAGE IN MEDICARE & MEDICAID:** Eliminates cost sharing for preventive services to encourage wider use of preventive care for Medicare beneficiaries. Requires State Medicaid programs to cover preventive services recommended to the Secretary of HHS based on evidence, such as tobacco cessation counseling for pregnant women.

**INCREASES REIMBURSEMENT FOR PRIMARY CARE IN MEDICAID:** Brings reimbursement for primary care services in Medicaid up to Medicare levels with 100% federal funding (phased in over several years).

**GIVES RURAL AND OTHER HOSPITALS DISCOUNTS ON DRUGS:** Extends discounted prices under the 340B program to certain rural and other hospitals for outpatient and inpatient drugs they dispense to their patients.

**ALLOWS STATES TO COVER LOW-INCOME INDIVIDUALS WITH HIV:** Gives States the option of extending Medicaid coverage to individuals infected with HIV and receiving enhanced federal matching payments for the costs of care.

**PROVIDES FOR 12-MONTH CONTINUOUS ELIGIBILITY IN CHIP:** Provides continuity of care for children by requiring that states provide 12-month continuous eligibility for children in the CHIP program

**INCREASES FUNDING FOR COMMUNITY HEALTH CENTERS:** Provides increased funding for community health centers that will allow them to double the number of patients served over the next five years.

**IMPLEMENTS NEW PREVENTIVE HEALTH SERVICES PROGRAM IN COMMUNITIES:** Provides immediate funding for preventive services at the community and local level to address public health problems such as obesity, tobacco use, and diabetes.

**EXPANDS PRIMARY CARE, NURSING AND PUBLIC HEALTH WORKFORCE:** Increases access to primary care by sustaining the current efforts to increase the size of the National Health Service Corps. Primary care and nurse training programs are also immediately expanded to increase the size of the primary care and nursing workforce. Ensures that public health challenges are adequately addressed.

**ESTABLISHES THE HEALTH BENEFITS ADVISORY COMMITTEE:** Establishes within 60 days of enactment, the Health Benefits Advisory Committee -- led by the Surgeon General and made up of health care experts, health care providers and patients -- provides recommendations on the essential benefits package to the Secretary of HHS for approval.

## 2011

**INCREASES VALUE OF HEALTH INSURANCE AND LOWERS PREMIUMS:** Requires health plans to meet minimum medical loss ratio standards as put forth by the Secretary of HHS.

**BEGINS TO FILL IN THE MEDICARE PART D DRUG DONUT HOLE:** Combines the PHRMA deal with funds raised by creating a Part D rebate only dual eligibles to significantly narrow the donut hole for prescription drug coverage in Medicare. The gap is narrowed over the coming years until it is fully eliminated.

**ELIMINATING BARRIERS TO ENROLLMENT IN MEDICARE LOW-INCOME SUBSIDY FOR PART D DRUG PROGRAM:** Eases burdens on enrollment so more low-income beneficiaries can get the financial help they need to make health care affordable.

**ESSENTIAL BENEFITS:** In preparation for reform, the Health Benefits Advisory Committee reports their recommended essential benefits package to the Secretary of HHS for adoption.

## 2012

**IMPROVES LOW-INCOME PROTECTIONS IN MEDICARE:** Increases the assets test limits in the Part D drug program and Medicare Savings Programs to ensure that more low-income beneficiaries get the financial help they need to make their health care affordable.

## 2013

**HEALTH INSURANCE REFORMS:** Implements strong health insurance reforms that prohibit insurance companies from engaging in discriminatory practices that enable them to refuse to sell or renew policies due to an individual's health status. In addition, they can no longer exclude coverage for treatments based on pre-existing health conditions. It also limits the ability of insurance companies to charge higher rates due to heath status, gender, or other factors. Premiums can vary only on age (no more than 2:1), geography and family size.

**HEALTH INSURANCE EXCHANGE:** Opens the Health Insurance Exchange to individuals without other coverage and to small employers under 10. This new venue will enable people to comparison shop for standardized health packages. It facilitates enrollment and administers affordability credits so that people of all incomes can obtain affordable coverage.

**PUBLIC HEALTH INSURANCE OPTION:** Creates a new public health insurance plan that is available only within the Health Insurance Exchange. It competes on a level playing field against private health plans. It will inject competition into the many parts of our country without a competitive health insurance market. Because it doesn't operate at the behest of investors, it will be able to offer stiff competition to private insurers – forcing them to compete on cost and quality for the first time.

**AFFORDABILITY CREDITS:** Makes Health Insurance Affordability Credits available through the Exchange to ensure people can obtain affordable coverage. Credits are available for people with incomes above Medicaid eligibility and below 400% of poverty who are not eligible for or offered other acceptable coverage. They apply to both premiums and cost sharing to ensure that no family faces bankruptcy due to medical expenses again.

**INDIVIDUAL RESPONSIBILITY:** Requires individuals to obtain acceptable health insurance coverage or pay a penalty of 2.5% of their income that is capped at the cost of the average cost of qualified coverage.

**EMPLOYER RESPONSIBILITY:** Employers are required to offer coverage to their workers and their workers families and meet standards for that coverage or pay a penalty of 8% of their payroll to help offset the cost of their workers obtaining coverage through the Exchange. Employers have a grace period and are not required to meet the benefit standards until 2018.

**PROTECTS SMALL BUSINESS:** Exempts small businesses with annual payrolls under $250,000 from the requirement to offer coverage, but their employees of exempt businesses obtain coverage through the Exchange. Employers with payrolls between $250,000 -$300,000 pay a 2% payroll penalty for failure to provide coverage, those with payrolls of $300,000 - $350,000 pay a 4% penalty, $350,000-$400,000 pay 6%. At $400,000 of annual payroll, the full 8% penalty is applicable.

**SMALL BUSINESS TAX CREDITS:** Provides certain lower-wage small businesses that choose to provide health coverage with a new tax credit worth up to 50% of the amount paid by a small employer for employee health coverage.

**EXPANDS MEDICAID ELIGIBILITY:** Expands Medicaid – with fully federal funding – to 133% of poverty to ensure that people obtain affordable health care in the most efficient and appropriate manner.

**PROTECTS THE HEALTH OF NEWBORN BABIES:** Provides temporary Medicaid coverage for up to 60 days for babies who are born without proof of other health coverage.

## 2014

**INITIATES AN AFFORDABILITY TEST FOR EMPLOYER-SPONSORED COVERAGE:** Opens the Health Insurance Exchange to individuals who have an offer of employer-sponsored coverage, but for whom that coverage would be unaffordable because the premium would absorb more than 11% of their family income. People who meet this test will be able to enter the Exchange and are eligible for affordability credits based on their incomes.

**HEALTH INSURANCE EXCHANGE EXPANDS:** Opens the Health Insurance Exchange to small businesses with up to 20 employees.

## 2015

**EXPANDS HEALTH INSURANCE EXCHANGE:** Provides the Health Choices Commissioner the authority to continue expanding the Exchange from this point forward to larger employers as the system is ready to handle increased capacity.

## 2018

**EMPLOYERS OUTSIDE THE EXCHANGE ARE REQUIRED TO MEET ESSENTIAL BENEFITS PACKAGE AND MINIMUM CONTRIBUTION LEVELS:** The grace period for employer sponsored plans to meet the health insurance standards ends. All employer sponsored coverage and health insurance offered within the exchange is required to meet benefit and contribution standards.


# Private Health Insurance Provisions of H.R. 3200

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# Summary

This report summarizes key provisions affecting private health insurance in H.R. 3200, America's Affordable Health Choices Act of 2009, as ordered reported by House Committees on Education and Labor and on Ways and Means. Specifically, this report focuses on Division A (or I) of H.R. 3200 from those committees.

Division A of H.R. 3200 focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, and providing financial assistance to certain individuals and, in some cases, small employers. In general, H.R. 3200 would require individuals to maintain health insurance and employers to either provide insurance or pay into a fund, with penalties/taxes for non-compliance. Several insurance market reforms would be made, such as modified community rating and guaranteed issue and renewal. Both the individual and employer mandates would be linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Acceptable coverage would include (1) coverage under a qualified health benefits plan (QHBP), which could be offered either through the newly created Health Insurance Exchange (the Exchange) or outside the Exchange through new employer plans; (2) grandfathered employment based plans; (3) grandfathered nongroup plans; and (4) other coverage, such as Medicare and Medicaid. The Exchange would offer private plans alongside a public option. Based on income, certain individuals could qualify for subsidies toward their premium costs and cost-sharing (deductibles and copayments); these subsidies would be available only through the Exchange. In the individual market (the nongroup market), a plan could be grandfathered indefinitely, but only if no changes were made to the terms and conditions of that plan, including benefits and cost-sharing, and premiums were only increased as allowed by statute. Most of these provisions would be effective beginning in 2013.

The Exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurers' plans in a comparable way. The Exchange would consist of a selection of private plans as well as a public option. Individuals wanting to purchase the public option or a private health insurance *not* through an employer or a grandfathered nongroup plan could *only* obtain such coverage through the Exchange. They would only be eligible to enroll in an Exchange plan if they were not enrolled in other acceptable coverage (e.g., from an employer, Medicare, and generally Medicaid). The public option would be established by the Secretary of Health and Human Services (HHS), would offer three different cost-sharing options, would vary premiums geographically, and would have payments to health care providers set by the Secretary based on Medicare payment rates, with adjustments.

Only within the Exchange, credits would be available to limit the amount of money individuals would pay for premiums. For example, a family of three at 133% of the federal poverty line ($24,352 in 2009 annual income) would be required to only pay annual premiums of $365 toward a Basic plan in the Exchange. A family of three at 400% of poverty ($73,240), where the premium subsidies end, would be required to pay no more than $8,056 in annual premiums for a Basic Exchange plan. Individuals eligible for premium credits would also be eligible for cost-sharing credits. (Although Medicaid is beyond the scope of this report, H.R. 3200 would extend Medicaid coverage for most individuals under 133⅓% of poverty; individuals would generally be ineligible for Exchange coverage if they were eligible for Medicaid.)

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## Appendixes



## Contacts

# Status of House Legislation

H.R. 3200, America's Affordable Health Choices Act of 2009, as introduced on July 14, 2009, was referred to the House Committees on Energy and Commerce, Ways and Means, Education and Labor, Oversight and Government Reform, and the Budget, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. The Committees on Education and Labor and on Ways and Means each ordered reported, as amended, their versions of H.R. 3200 on July 17, 2009. The Committee on Energy and Commerce has held several days of markup. The Committees on Oversight and Government Reform and the Budget have not taken up the legislation for consideration.

# Overview of H.R. 3200

This report summarizes the key provisions affecting private health insurance in America's Affordable Health Choices Act of 2009, found in Division A, as ordered reported by House Committees on Ways and Means and on Education and Labor.[1] Division A of H.R. 3200 focuses on reducing the number of uninsured, restructuring the private health insurance market, setting minimum standards for health benefits, providing financial assistance to certain individuals, and, in some cases, small employers. In general, H.R. 3200 would include the following:

- Individuals would be required to maintain health insurance, and employers would be required to either provide insurance or pay into a fund, with penalties/taxes for noncompliance.
- Several market reforms would be made, such as modified community rating and guaranteed issue and renewal.
- Both the individual and employer mandates would be linked to acceptable health insurance coverage, which would meet required minimum standards and incorporate the market reforms included in the bill. Acceptable coverage would include
  - coverage under a qualified health benefits plan (QHBP), which could be offered either through the newly created Exchange or outside the Exchange through new employer plans;
  - grandfathered employment based plans;
  - grandfathered nongroup plans; and
  - other coverage, such as Medicare and Medicaid.
- The Exchange would be established under a new independent federal agency (the Health Choices Administration), headed by a Commissioner. The Exchange would offer private plans alongside a public option.

[1] Some of the legislative versions have this as Division I, even though the other two divisions in H.R. 3200 are Division B and Division C.

- Certain individuals with incomes below 400% of the federal poverty level could qualify for subsidies toward their premium costs and cost-sharing; these subsidies would be available only through the Exchange.
- In the individual market (the nongroup market), a plan could be grandfathered indefinitely, but only if no changes were made to the terms and conditions of the plan, including benefits and cost-sharing, and premiums were only increased as allowed by statute.
- This bill would not affect plans covering specific services, such as dental or vision care.
- Most of these provisions would be effective beginning in 2013.

# Overview of Report

This report provides a short background describing key aspects of the private insurance market as it exists currently. This information is useful in setting the stage for understanding how and where H.R. 3200 would reform health insurance. Primarily, however, the report summarizes provisions affecting private health insurance in Division A (or Division 1) H.R. 3200,[2] as ordered reported by the House Committees on Education and Labor and on Ways and Means. Where the House committees' versions of a provision are the same, they are discussed as applying generally under H.R. 3200; where the bills ordered reported differ, the differences are noted. Although most of the provisions would be effective beginning in 2013, the table in the **Appendix** shows the timeline for implementing provisions effective prior to 2013.

Although the description that follows segments the private health insurance provisions into various categories, these provisions are interrelated and interdependent. For example, H.R. 3200 includes a number of provisions to alter how current private health insurance markets function, primarily for individuals who purchase coverage directly from an insurer or through a small employer. H.R. 3200 would require that insurers not exclude potential enrollees or charge them premiums based on pre-existing health conditions. In a system where individuals voluntarily choose whether to obtain health insurance, however, individuals may choose to enroll only when they become sick. Enrolling in coverage only after developing a condition could result in coverage that excludes the pre-existing condition, unaffordable premiums, and even greater uninsurance. Thus, America's Health Insurance Plans (AHIP), the association that represents health insurers, has agreed to reform that does away with limitations of pre-existing condition exclusions, but only if individuals are required to purchase coverage, so that not just the sick enroll.[3]

However, some individuals currently forgo health insurance because they cannot afford the premiums. If individuals are required to obtain health insurance, one could argue that adequate premium subsidies must be provided by the government and/or employers to make practical the

[2] This report does not address Divisions B or C, which will be addressed in forthcoming reports.

[3] AHIP, "Health Plans Propose Guaranteed Coverage for Pre-Existing Conditions and Individual Coverage Mandate," November 19, 2008, available at http://www.ahip.org/content/pressrelease.aspx?docid=25068. See also Blue Cross Blue Shield Association, "BCBSA Announces Support for Individual Mandate Coupled with a Requirement for Insurers to Offer Coverage to All," November 19, 2008, at http://www.bcbs.com/news/bcbsa/bcbsa-announces-support-for.html.

individual mandate to obtain health insurance, which is in turn arguably necessary to make the market reforms possible. In addition, premium subsidies without cost-sharing subsidies may provide individuals with health insurance that they cannot afford to use. So, while the descriptions below discuss various provisions separately, the removal of one from the bill could be deleterious to the implementation of the others.

The private health insurance provisions are presented under the following topics within Division A of H.R. 3200, with the primary CRS contact listed for each:

- Individual and employer mandate: the requirement on individuals to maintain health insurance and on employers to either provide health insurance or pay into the Exchange, with penalties and taxes for noncompliance.
  [Titles III and IV—Hinda Chaikind, 7-7569]
- Private health insurance market reforms.
  [Title I—Bernadette Fernandez, 7-0322]
- Health Insurance Exchange [Title II, Subtitle A—Chris Peterson, 7-4681], through which the following two items can only be offered:
  - Public Health Insurance Option.
    [Title II, Subtitle B—Paulette Morgan, 7-7317]
  - Premium and cost-sharing subsidies.
    [Title II, Subtitle C—Chris Peterson, 7-4681]

# Background

Americans obtain health insurance in different settings and through a variety of methods. People may get health coverage in the private sector or through a publicly funded program, such as Medicare or Medicaid. In 2007, approximately 177 million persons had employment-based health insurance, which accounts for nearly 60% of the total population.[4] Employers choosing to offer health coverage may either purchase insurance or choose to self-fund health benefits for their employees. Other individuals obtained coverage on their own in the nongroup market. However, there is no federal law that either requires individuals to have health insurance or requires employers to offer health insurance. Approximately 46 million Americans were estimated to be uninsured in 2007.

Individuals and employers choosing to purchase health insurance in the private market fit into one of the three segments of the market, depending on their situation—the large group (large employer) market, the small group market, and the nongroup market.[5]

More than 95% of large employers offer coverage. Large employers are generally able to obtain lower premiums for a given health insurance package than small employers and individuals

[4] CRS Report 96-891, *Health Insurance Coverage: Characteristics of the Insured and Uninsured Populations in 2007*, by Chris L. Peterson and April Grady.

[5] Health insurance can be provided to groups of people that are drawn together by an employer or other organization, such as a trade union. Small groups typically refer to firms with between 2 and 50 workers, although some self-employed individuals are considered "groups of one" for health insurance purposes in some states. Consumers who are not associated with a group can obtain health coverage by purchasing it directly in the nongroup (or individual) market.

seeking nongroup coverage. This is partly because larger employers enjoy economies of scale and a larger "risk pool" of enrollees that makes the expected costs of care more predictable. Employers generally offer large subsidies toward health insurance, thus making it more attractive for both the healthier and the sicker workers to enter the pool. So, not only is the risk pool larger in size, but it is more diverse. States have experimented with ways to create a single site where individuals and small employers could compare different insurance plans, obtain coverage, and sometimes pool risk. Although most of these past experiments failed (e.g., California's PacAdvantage[6]), other states have learned from these experiences and have fashioned potentially more sustainable models (e.g., Massachusetts' Connector[7]). There are private-sector companies that also serve the role of making various health insurance plans easier to compare for individuals and small groups (e.g., eHealthInsurance), available in most, but not all, states because of variation in states' regulations.

Less than half of all small employers (less than 50 employees) offer health insurance coverage, in part because they lack the economies of scale available to larger employers. These pools are generally considered to be less stable than larger pools, as one or two employees moving in or out of the pool (or developing an illness) would have a greater impact on the risk pool than they would in a larger pool. Allowing these firms to purchase insurance through a larger pool, such as an Association or an Exchange, could lower premiums for those with high-cost employees.

Depending on the applicable state laws, individuals who purchase health insurance in the nongroup market may be rejected or face premiums that reflect their health status, which can make premiums lower for the healthy but higher for the sick. Even when these individuals obtain coverage, there may be exclusions for certain conditions. Reforms affecting premiums ratings would likely increase premiums for some, while lowering premiums for others, depending on their age, health, behaviors, and other factors.

States are the primary regulators of the private health insurance market, though some federal regulation applies, mostly affecting employer-sponsored health insurance (ESI).[8] The Health Insurance Portability and Accountability Act (HIPAA) requires that coverage sold to small groups (2-50 employees) must be sold on a guaranteed issue basis. That is, the issuer must accept every small employer that applies for coverage. All states require issuers to offer policies to firms with 2-50 workers on a guaranteed issue basis, in compliance with HIPAA. As of January 2009 in the small group market, 13 states also require issuers to offer policies on a guaranteed issue basis to the self-employed "groups of one." And as of December 2008 in the individual market, 15 states require issuers to offer some or all of their insurance products on a guaranteed issue basis to non-HIPAA eligible individuals. Most states currently impose rating rules on insurance carriers in the small group and individual markets. The spectrum of existing state rating limitations ranges from pure community rating to adjusted (or modified) community rating, to rate bands, to no

[6] Pac Advantage was created as part of the small business health insurance reforms enacted in California in 1992, as a state-established health insurance pool to help cover small-business employees in California. PacAdvantage was created to allow small businesses to band together and negotiate lower insurance premiums for their employees, but it did little to make insurance more affordable. Over time, employers whose workers had the lowest health risks exited the pool for plans with cheaper premiums, leaving the program with the highest-risk members and driving up costs.

[7] See http://www.mahealthconnector.org.

[8] Federal law mandates compliance if an employer chooses to offer health benefits, such as compliance with plan fiduciary standards, procedures for appealing denied benefit claims, rules for health care continuation coverage, limitations on exclusions from coverage based on preexisting conditions, and a few benefit requirements such as minimum hospital stay requirements for mothers following the birth of a child.

restrictions. Generally, community rating prohibits issuers from pricing health insurance policies based on health factors, but allows it for other factors such as age or gender. All states require health issuers to reduce the period of time when coverage for pre-existing health conditions may be excluded. As of January 2009 in the small group market, 21 states had pre-existing condition exclusion rules that provided consumer protection above the federal standard. And as of December 2008 in the individual market, 42 states limit the period of time when coverage for pre-existing health conditions may be excluded for non-HIPAA eligible enrollees in that market. In fact, while there are a handful of federal benefit mandates for health insurance that apply to group coverage, there are more than 2,000 benefit mandates imposed by the states.

One issue receiving congressional attention is whether a publicly sponsored health insurance plan should be offered as part of the insurance market reform. Some proponents of a public option see it as potentially less expensive than private alternatives, as it would not need to generate profits or pay brokers to enroll individuals and might have lower administrative costs. Some proponents argue that offering a public plan could provide additional choice and may increase competition, since the public plan might require lower provider payments and thus charge lower premiums. Some opponents question whether these advantages would make the plan a fair competitor, or rather provide the government with an unfair advantage in setting prices, in authorizing legislation, or in future amendments. Ultimately, they fear that these advantages might drive private plans from the market.[9]

# Individual and Employer Mandates

## Individual Mandate

H.R. 3200 includes an individual mandate to have health insurance, with penalties for noncompliance. Individuals would be required to maintain acceptable coverage, defined as coverage under a qualified health benefits plan (QHBP), an employment-based plan, a grandfathered nongroup plan, Part A of Medicare, Medicaid, military coverage (including Tricare), Veteran's health care program, and coverage as determined by the Secretary in coordination with the Commissioner. Individuals who did not maintain acceptable health insurance coverage for themselves and their children would be required to pay an additional tax, prorated for the time the individual (or family) does not have coverage, equal to the lesser of (1) 2.5 % of the taxpayer's modified adjusted gross income[10] (MAGI) over the amount of income required to file a tax return, or (2) the national average premium for applicable single or family coverage.

Some individuals would be provided with subsidies to help pay for the costs of their premiums and cost-sharing. (A complete description of who is eligible and the amount of subsidies is found

[9] Currently, Medicare is an example of a federal public health insurance program for the aged and disabled. Under Medicare, Congress and the Department of Health and Human Services (HHS) Centers for Medicare and Medicaid Services (CMS) determine many parameters of the program. These include eligibility rules, financing (including determination of payroll taxes, and premiums), required benefits, payments to health care providers, and cost-sharing amounts. However, even within this public plan, CMS subcontracts with private companies to carry out much of the administration of the program.

[10] For this purpose, MAGI is defined as adjusted gross income (AGI) without the exclusions for U.S. citizens or residents living abroad, plus tax-exempt interest.

in the section on premium and cost-sharing credits). Others would be exempt from the individual mandate, including nonresident aliens, individuals residing outside of the United States, individuals residing in possessions of the United States, those with qualified religious exemptions, those allowed to be a dependent for tax-filing purposes, and others granted an exemption by the Secretary.

## Employer Mandate

H.R. 3200 would require employers either to provide full-time employees with a QHBP (or current employment-based plan) or to pay a set amount into the Exchange. Employers would include private sector employers, federal, state, and tribal governmental plans, and church plans. Under the Education and Labor bill, an employer could apply to the Secretary for a waiver from health coverage participation requirements for any two-year period.

For those employers that chose to offer health insurance, the following rules would apply:

- Employers could offer employment-based coverage, or they could offer coverage through an Exchange plan (if the employer was eligible to participate in the Exchange—see section on rules for the Exchange).
- Current employment-based health plans would be grandfathered for five years, at which time any plan offered by an employer would have to meet (but could exceed) the requirements of the essential benefits package.
- Employers would have to contribute at least 72.5% of the lowest-cost qualified benefits plan they offered[11] (65% for those electing family coverage)—prorated for part-time employees.
- Salary reductions used to offset required employer contributions would not count as amounts paid by the employer.
- Employers would automatically enroll their employees into the plan for individual coverage with the lowest associated employee premium, unless the employee selected a different plan or opted out of employer coverage.

In general, employers that elected to provide coverage but failed to meet minimum health coverage participation requirements would be subject to a tax of $100 per day for each employee to whom the failure applied. This tax would not apply for failures corrected within 30 days, in cases where the employer could not have reasonably been aware of the failure, and other exceptions. The tax would be limited to the lesser of 10% of the employment-based health plan costs for the prior year or $500,000.

Employers with aggregate wages over $400,000 that chose not to offer coverage would be required to make contributions equal to 8% of the average wages paid by the employer. Small employers with aggregate wages below $250,000 would be exempt from requirements. Those with aggregate wages over $250,000 and below $300,000 would be required to pay 2% of average wages, those with aggregate wages over $300,000 and below $350,000 would be

[11] For employers offering coverage through Exchange plans, their minimum contribution would be based on the reference premium amounts (as defined in the Exchange) for the premium rating area in which the individual or family resides.

required to pay 4%, and those with aggregate wages above $350,000 and below $400,000 would be required to pay 6%.

Even if an employer offered employer sponsored health insurance, employees could decline or disenroll from this insurance and instead enroll in a plan through the Exchange. Beginning in the second year after enactment, employers with aggregate wages above $400,000 would be required to make contributions equal to 8% of average wages paid by the employer to the Exchange, for those employees, with similar adjustments for small employers as those described above. The employer's contribution for this group of individuals would go into the Exchange but would not apply toward the individual's premium (i.e., absent the limited instances of qualifying for a subsidy,[12] such individual would be responsible for 100% of the premium in the Exchange). This contribution would not be required for an employee who was not the primary insured individual but was covered as a spouse or dependent in an Exchange plan.

Within 90 days after enactment, H.R. 3200 would create a temporary reinsurance program, with funding not to exceed $10 billion, to assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older and their dependents. The Secretary would reimburse the plan for 80% of the portion of a claim above $15,000 and below $90,000 (adjusted annually for inflation). Amounts paid to the plan would be used to lower costs directly to participants in the form of premiums, co-payments, and other out-of-pocket costs, but could be not used to reduce the costs of an employer maintaining the plan.

The Education and Labor bill adds a provision that would bar group health plans from reducing retiree health benefits for either the retiree or their beneficiaries (as of the date the participant retired) unless such reduction was also made with respect to active participants.

Finally, the Education and Labor bill contains a provision that would allow the Commissioner to enter into arrangements with small employer benefit associations to provide consumer information, outreach, and assistance in the enrollment of small employers and their employees who are members of such an association, under Exchange participating health benefits plans.

## Small Business Credit

Certain small businesses would be eligible for a 50% credit toward the cost of coverage. This credit would be phased out as average employee compensation increased from $20,000 to $40,000, then as the number of employees increased from 10 to 25. Employees would be counted if they received at least $5,000 in compensation, but the credit would not apply toward insurance for employees whose compensation exceeded $80,000. This credit would be treated as part of the general business credit and would not be refundable; it would be available only to a business with a tax liability.

[12] Beginning in 2014, full-time employees whose premium costs under a group health plan exceed 11% of family income could obtain premium credits.

# Private Health Insurance Market Reforms

## Qualified Health Benefits Plans (QHBPs)

H.R. 3200 would establish new federal health insurance standards applicable to new, generally available health plans specified in the bill—"qualified health benefits plans" (QHBPs). Among the market reforms applicable to QHBPs are provisions that would do the following:

- Prohibit coverage exclusions of pre-existing health conditions. (A "pre-existing health condition" is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, cares, or treatment was recommended or received before such date.)
- Require premiums to be determined using adjusted community rating rules. ("Adjusted, or modified community rating" prohibits issuers from pricing health insurance policies based on health factors, but allows it for other key characteristics such as age or gender.) Under H.R. 3200, premiums would only be allowed to vary based on age—by no more than a 2:1 ratio within age categories specified by the Commissioner, premium rating areas, and family enrollment—for example, for single versus family coverage.
- Require coverage to be offered on both a guaranteed issue and guaranteed renewal basis. ("Guaranteed issue" in health insurance is the requirement that an issuer accept every applicant for health coverage. "Guaranteed renewal" in health insurance is the requirement on an issuer to renew group coverage at the option of the plan sponsor [e.g., employer] or nongroup coverage at the option of the enrollee. Guaranteed issue and renewal alone would not guarantee that the insurance offered was affordable; this would be addressed in the rating rules.)
- Impose new non-discrimination building on existing non-discrimination rules in group coverage and adequacy standards for insurers' networks of providers, such as doctors.

H.R. 3200 would also require QHBPs to cover certain broad categories of benefits, prohibit cost-sharing on preventive services, limit annual out-of-pocket spending, and meet the standards for the "essential benefits package," described below. In addition, under the Ways and Means version, QHBPs would comply with a medical loss ratio[13] standard to be determined by the Commissioner. Under the Education and Labor version, QHBPs would be required to meet a medical loss ratio of 85%.

New individual policies issued post enactment could be offered only as an Exchange plan. Existing group plans would have to transition to QHBP standards by 2018. Existing nongroup insurance policies would be grandfathered as long as there are no changes to the terms or conditions of the coverage (except as required by law), including benefits and cost-sharing. Such

[13] Medical loss ratio is the share (expressed as a percentage) of total premium revenue spent on medical claims, as opposed to administration or profit.

policies would be required to meet other conditions, including increasing premiums only according to statute.

In addition, the Education and Labor version would shorten the current federal allowance for pre-existing health conditions exclusions (from 12 months to 3 months for most individuals) effective 6 months after enactment of the bill, and applicable until such time that federal standards eliminate exclusions for pre-existing health conditions. Special rules would apply to health plans subject to collective bargaining agreements.

## Essential Benefits Package

QHBPs would be required to cover at least an "essential benefit package" but could offer additional benefits. The essential benefits package would cover specified items and services, limit cost-sharing, prohibit annual and lifetime limits on covered services, ensure the adequacy of provider networks, and are equivalent (as certified by the Office of the Actuary of the Centers for Medicare and Medicaid Services) to the average prevailing employer-sponsored coverage.

The essential benefits package would be required to cover the following items and services:

- hospitalization;
- outpatient hospital and clinic services, including emergency department services;
- services of physicians and other health professionals;
- services, equipment, and supplies incident to the services of a physician or health professional in appropriate settings;
- prescription drugs;
- rehabilitative and "habilitative" services (i.e., services to maintain the physical, intellectual, emotional, and social functioning of developmentally delayed individuals);
- mental health and substance use disorder services;
- certain preventive services (with no cost-sharing permitted) and vaccines;
- maternity care;
- under the Ways and Means version, well baby and well child care *and* oral health, vision, and hearing services, equipment, and supplies for those under age 21;
- under the Education and Labor version, well baby and well child care *and* early and period screening, diagnostic and treatment services (EPSDT, as available under Medicaid) for those under age 21; and
- under the Education and Labor version, durable medical equipment, prosthetics, orthotics, and related supplies.

The annual out-of-pocket limit in 2013 would be $5,000 for an individual and $10,000 for a family, adjusted annually for inflation. To the extent possible, the Commissioner would establish cost-sharing levels using copayments (a flat dollar fee) and not coinsurance (a percentage fee).

Cost-sharing under the essential benefits package would be designed so that the plan covers approximately 70% of the full value of benefits in the essential benefits package; QHBPs could cover a higher percentage.

### Health Benefits Advisory Committee

A Health Benefits Advisory Committee (HBAC) would be established to make recommendations to the Secretary regarding coverage offered through the Health Insurance Exchange, including covered benefits, cost-sharing, and updates to the essential benefits package. The Committee would develop cost-sharing structures to be consistent with actuarial values specified for different plan tiers (i.e., Basic, Enhanced, and Premium plans) offered in the Exchange. In developing its recommendations, the Committee would incorporate innovation in health care, consider how the benefits package would reduce health disparities, and allow for public input as part of developing its recommendations.

# Health Insurance Exchange

## Exchange Structure

In addition to federalizing private health insurance standards, H.R. 3200 would also create a "Health Insurance Exchange," similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance, to facilitate the purchase of QHBPs by certain individuals and small businesses. The Exchange would not be an insurer; it would provide eligible individuals and small businesses with access to insurers' plans in a comparable way (in the same way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). The Exchange would have additional responsibilities as well, such as negotiating with plans, overseeing and enforcing requirements on plans (in coordination with state insurance regulators), and determining eligibility for and administering premium and cost-sharing credits.

Under H.R. 3200, the Exchange would be established under a new independent federal agency (the Health Choices Administration), headed by a Commissioner. The federal Exchange's startup and operating costs, along with payments for premium and cost-sharing credits discussed below, would be paid for out of a new Health Insurance Exchange Trust Fund, funded by (1) taxes on certain individuals who did not obtain acceptable coverage, (2) penalties for employers whose coverage failed to meet the requirements for coverage, (3) payments by employers who opted not to provide insurance coverage, (4) payments by employers whose employees opt for Exchange coverage instead of employment-based coverage, and (5) such additional sums as necessary to be appropriated for the Exchange.

Only one Exchange could operate in a state. The Commissioner would be required to approve a state-based Exchange that met specified criteria. (A group of states could also operate an Exchange.) A state-based Exchange would be funded through a federal matching grant to states. Under the Education and Labor version, a state may operate a "single payer system," in which the state could require and set employer contributions and use a single state agency to finance and administer all health care benefits for its residents.

Individuals could obtain coverage outside the Exchange, and insurers could offer plans outside the Exchange (through employer and grandfathered plans). However, the Public Health Insurance Option and the income-based premium and cost-sharing credits would be available only through the Exchange.

## Individual and Employer Eligibility for Exchange Plans

Under H.R. 3200, beginning in 2013, individuals would be eligible for Exchange coverage unless they were enrolled in any of the following:

- a group plan through a full-time employee (including a self-employed person with at least one employee) for which the employer makes an adequate contribution (described in the section on employer mandates),
- Medicare,
- Medicaid (except in certain cases),[14]
- Department of Defense (DOD) medical benefits (including Tricare), and
- Veterans Affairs (VA) coverage, with some exceptions.[15]

With some exceptions, individuals would lose eligibility for Exchange coverage once they become *eligible* for Medicare Part A, Medicaid, and other circumstances as the Commissioner provides. Besides those cases, once individuals enroll in an Exchange plan, they would continue to be eligible until they are no longer enrolled.

An open-enrollment period would be offered annually, sometime during September to November, lasting at least 30 days. There would also be special enrollment periods for certain circumstances (e.g., loss of acceptable coverage, change in marital or dependent status).

Exchange-eligible employers could meet the requirements of the employer mandate by offering and contributing adequately toward employees' enrollment through the Exchange. Those employees would be able to choose any of the available Exchange plans. Once employers are Exchange eligible and enroll their employees through the Exchange, they would continue to be Exchange eligible, unless they decided to then offer their own QHBPs.

In the Ways and Means version of H.R. 3200, in 2013, employers with 10 or fewer employees would be Exchange-eligible. In 2014, employers with 20 or fewer employees would be Exchange-eligible. Beginning in 2015, the Commissioner could permit larger employers to

[14] Regarding Medicaid, individuals could still participate in the Exchange if their Medicaid eligibility was related to COBRA continuation coverage, tuberculosis, or breast or cervical cancer. Section 1701 of H.R. 3200, which is beyond the scope of this report, requires states with Medicaid programs to expand coverage to individuals up to 133⅓% of the federal poverty level who are not eligible under current state Medicaid programs. These newly eligible individuals are called "non-traditional Medicaid eligible individuals" in H.R. 3200. A non-traditional Medicaid eligible individual could be Exchange-eligible if the individual was enrolled in a qualified health benefits plan, grandfathered health insurance coverage, or current group health plan during the six months before the individual became a non-traditional Medicaid eligible individual. During the period in which such an individual had chosen to enroll in an Exchange plan, the individual would be ineligible for regular Medicaid.

[15] Individuals receiving VA care could be eligible for an Exchange plan if the Commissioner, in coordination with the Treasury Secretary, determined that the coverage did not meet a level specified by the Commissioner and the VA Secretary, in coordination with the Treasury Secretary.

participate in the Exchange; these additional employers could be phased in or made eligible based on the number of full-time employees or other considerations the Commissioner deems appropriate.

In the Education and Labor version of H.R. 3200, in 2013, employers with 15 or fewer employees would be Exchange-eligible. In 2014, employers with 25 or fewer employees would be Exchange-eligible. In 2015, employers with 50 or fewer employees would be Exchange-eligible. Beginning in 2015, the Commissioner could permit larger employers to participate in the Exchange; these additional employers could be phased in or made eligible based on the number of full-time employees or other considerations the Commissioner deems appropriate.

### Benefit Packages in the Exchange

Exchange plans would have to meet not only the new federal requirements of all private health insurance plans (i.e., be QHBPs), but would also have their cost-sharing options somewhat standardized into the following four cost-sharing/benefit tiers:

- An Exchange-participating "entity" (insurer) must offer only one Basic plan in the service area. The Basic plan would be equivalent to the minimum requirements of the essential benefits package (e.g., actuarial value of approximately 70%).
- If the entity offers a Basic plan in a service area, it may offer one Enhanced plan in the service area, which would have a lower level of cost-sharing for benefits in the essential benefits package (i.e., actuarial value of approximately 85%).
- If the entity offers an Enhanced plan in a service area, it may offer one Premium plan in the service area, which would have a lower level of cost-sharing for benefits in the essential benefits package (i.e., actuarial value of approximately 95%).
- If the entity offers a Premium plan in a service area, it may offer one or more Premium-Plus plans in the service area. A Premium-Plus plan is a Premium plan that also provides additional benefits, such as adult oral health and vision care.

Plans would use the cost-sharing levels specified by the HBAC for each benefit category in the essential benefits package, for each cost-sharing tier (Basic, Enhanced and Premium)—although plans would be permitted to vary the cost-sharing from HBAC's specified levels by up to 10%. If a state requires health insurers to offer benefits beyond the essential benefits package, such requirements would continue to apply to Exchange plans, but only if the state has entered into an arrangement satisfactory to the Commissioner to reimburse the Commissioner for the amount of any resulting net increase in premium credits.

## Public Health Insurance Option

Under H.R. 3200, the Secretary of Health and Human Services (HHS) would establish a public health insurance option through the Exchange. Any individual eligible to purchase insurance through the Exchange would be eligible to enroll in the public option, and may also be eligible for income-based premium and cost-sharing credits. The public option would have to meet the

requirements that apply to all Exchange-participating plans, including those related to benefits, provider networks, consumer protections, and cost-sharing. The public option would be required to offer Basic, Enhanced, and Premium plans, and could offer Premium-Plus plans.

The Secretary would be required to establish geographically adjusted premiums that comply with the premium rules established by the Commissioner and at a level sufficient to cover expected costs (including both claims and administration). Limited start-up funding would be available, but would be repaid within 10 years.

The Secretary would be required to establish payment rates for services and health care providers, and would have the authority to change payment rates in accordance with reforms. In general, during the first three years of the public option, the Secretary would be required to base payment rates on the rates for similar services and providers under Medicare, with adjustments.[16] Physicians would be able to participate in the public option as preferred or non-preferred providers; preferred physicians would be prohibited from balance-billing, that is billing amounts above the established rates, while non-preferred physicians could balance-bill up to 115% of the established payment rate. Non-physician providers would be prohibited from balance-billing. Payments for outpatient prescription drugs would be based on negotiated rates.

Medicare-participating providers would also be providers for the public option, unless they chose to opt out. For the first three years of the public option, physicians and other health care practitioners who participate in both Medicare and the public option, and certain other providers, would receive a 5% payment increase above the adjusted Medicare rate. Beginning in the fourth year, the Secretary would use an administrative process to establish rates to promote payment accuracy, to ensure adequate beneficiary access to providers, or to promote affordability and the efficient delivery of health care. The Secretary could not set rates at levels expected to increase overall medical costs beyond what would have been expected if payments were set at the adjusted Medicare level plus 5%. The Secretary would also have the authority to use innovative payment mechanisms and policies to determine payments for items and services under the public option.

The Secretary would be allowed to enter into no-risk contracts for the administration of the public option, in the same way the Secretary enters into contracts for the administration of the Medicare program. The administrative functions would include, subject to restrictions, determination of payment amounts, making payments, beneficiary education and assistance, provider consultative services, communication with providers, and provider education and technical assistance.

## Premium and Cost-Sharing Credits

Some individuals would be eligible for premium credits (i.e., subsidies) toward their required purchase of health insurance, based on income. However, even when individuals have health insurance, they may be unable to afford the cost-sharing (deductible and copayments) required to obtain health care. Thus subsidies may also be necessary to lower the cost-sharing. Under H.R.

[16] The payments for physicians' services otherwise established under Medicare would be applied to the public option without regard to the sustainable growth rate—one component of the formula used to update Medicare payments to physicians. The yearly update for payments for physicians' services under the public option would not be less than 1%. Also, the Secretary would have authority to determine which adjustments to base payment rates under Medicare would apply to rates under the public option.

3200, those eligible for premium credits would also be eligible for cost-sharing credits (i.e., subsidies).

In 2103 and 2014, these subsidies would only be available for Basic plans sold through the Exchange, including both the private plans and public option. Beginning in 2015, individuals eligible for credits could obtain an Enhanced or Premium plan, but would be responsible for any additional premiums. Beginning in 2014, employers would be required to pay an amount to the Exchange for any employee choosing coverage in the Exchange, regardless of whether the employee had access to the subsidies; however, in this case, the employer's contribution would not be applied toward the individual's premium.

## Individual Eligibility for Premium Credits and Cost-Sharing Credits

Under H.R. 3200, Exchange-eligible individuals could receive a credit in the Exchange if they

- are lawfully present in a state in the United States, with some exclusions;[17]
- are not enrolled under an Exchange plan as an employee or their dependent (through an employer who purchases coverage for its employees through the Exchange and satisfies the minimum employer premium contribution amounts);[18]
- are not a full-time employee in a firm where the employer offers health insurance and makes the required contribution toward that coverage;[19]
- have modified adjusted gross income[20] (MAGI) of less than 400% of the federal poverty level (FPL);[21] and
- are ineligible for Medicaid, except for the few previously mentioned exceptions.[22]

[17] Nonimmigrants are those who are in the United States for a specified period of time and a specific purpose. The exceptions include aliens with nonimmigrant status because they are trafficking victims, crime victims, fiancées of U.S. citizens, or have had applications for legal permanent residence (LPR) status pending for three years. It is expected that almost all aliens in these nonimmigrant categories will become LPRs (i.e., immigrants) and remain in the United States permanently.

[18] The Commissioner would make exceptions to this rule for divorced or separated individuals, or dependents of employees who would otherwise be eligible for credits. Exceptions would also be made, beginning in 2014, for full-time employees whose premium costs under a group health plan exceed 11% of family income.

[19] Exceptions would be made for certain individuals (e.g., divorced or separated individuals). Exceptions would also be made, beginning in 2014, for full-time employees of any income whose premium costs under a group health plan exceed 11% of family income.

[20] For this purpose, MAGI is defined as adjusted gross income (AGI) without the exclusions for U.S. citizens or residents living abroad, plus tax-exempt interest.

[21] The federal poverty level used for public program eligibility varies by family size and by whether the individual resides in the 48 contiguous states and the District of Columbia versus Alaska and Hawaii. For a two-person family in the 48 contiguous states and the District of Columbia, the federal poverty level (i.e., 100% of poverty) was $14,570. See 74 *Federal Register* 4200, January 23, 2009, http://aspe.hhs.gov/poverty/09fedreg.pdf.

[22] Exceptions to the Medicaid prohibition are described in an earlier footnote. H.R. 3200 includes extending Medicaid eligibility extended to most individuals with income of 133⅓% FPL or less, although income is counted differently for Medicaid than for MAGI.

If individuals apply for a premium credit, the Exchange would first determine whether they are eligible for Medicaid and, if so, would facilitate their enrollment into Medicaid ("screen and enroll").

## Calculation of Premium Credit

The premium credit is based on what is considered an "affordable premium amount" for individuals to pay. The affordable premium amount is a percentage of individuals' income (MAGI) relative to the poverty level, as specified in the table below. For more details on the premium credits than provided here, see CRS Report R40734, *Health Insurance Premium Credits Under H.R. 3200.*

| **Federal poverty level (FPL)** | **Premium payment limit** (as a percent of income) |
|---|---|
| 133% or less | 1.5% |
| 150% | 3.0% |
| 200% | 5.0% |
| 250% | 7.0% |
| 300% | 9.0% |
| 350% | 10.0% |
| 400% | 11.0% |

For example, a family of three at 133% of the federal poverty line ($24,352 in 2009 annual income) would be required to only pay annual premiums of $365 toward a Basic plan in the Exchange. A family of three at 400% of poverty ($73,240), where the premium subsidies end, would be required to pay no more than $8,056 in annual premiums for a Basic Exchange plan.

More specifically, the premium against which credits would be calculated—the "reference premium"—would be the three Basic plans with the lowest premiums in the area (although the Commissioner could exclude plans with extremely limited enrollment). The "affordability premium credit" would be the lesser of (1) how much the enrollee's premium exceeds the affordable premium amount, or (2) how much the reference premium exceeds the affordable premium amount.

The Commissioner would establish premium percentage limits so that for individuals whose family income is between the income tiers specified in the table above, the percentage limits would increase on a linear sliding scale. The affordable premium credit amount would be calculated on a monthly basis.

## Calculation of Cost-Sharing Credit

In addition, those who qualified for premium credits would also be eligible for assistance in paying any required cost-sharing for their health services. The Commissioner would specify

reductions in cost-sharing amounts and the annual limitation (out-of-pocket maximum) on cost-sharing under a Basic plan so that the average percentage of covered benefits paid by the plan (as estimated by the Commissioner) is equal to the percentages (actuarial values) in the table for each income tier.

| **Federal poverty level (FPL)** | **Actuarial value** (percentage) |
|---|---|
| 150% or less | 97% |
| 200% | 93% |
| 250% | 85% |
| 300% | 78% |
| 350% | 72% |
| 400% | 70% |

The Commissioner would pay insurers additional amounts to cover the reduced cost-sharing provided to credit-eligible individuals.

# Appendix. Timeline of Implementation Dates Under Division A of H.R. 3200 Prior to Full Implementation of January 1, 2013

| Implementation date | Section in H.R. 3200 | Provision |
|---|---|---|
| "hereby established" | 141, 201 | Establishment of a new independent federal agency, Health Choices Administration, headed by a Commissioner, to issue regulations regarding private health insurance, oversee the Exchange, and administer premium and cost-sharing credits. |
| 60 days after enactment | 123 | Members appointed to the Health Benefits Advisory Committee (HBAC), which will recommend to the Secretary of Health and Human Services (HHS) private health insurance benefit standards, including cost-sharing amounts, for the "essential benefits package" and for Basic, Enhanced and Premium plans in the Exchange. |
| 90 days after enactment | 164 | Creation of a temporary reinsurance program, with funding not to exceed $10 billion, to assist participating employment-based plans with the cost of providing health benefits to eligible retirees who are 55 and older and their dependents. |
| 6 months after enactment | 163 | Secretary to submit to Congress a plan for implementing and enforcing new electronic financial and administrative standards, based on the existing HIPAA standards, within 5 years of enactment. |
| 7/1/2010 | 162 | Secretary to issue guidance regarding rescissions in the individual market, that an insurer could not rescind a policy without clear and convincing evidence of fraud. |
| 10/1/2010 | 162 | Effective date of amendments to existing statute and Secretary's guidance regarding rescissions in the individual market, regardless of issue date of individual coverage. |
| 1 year after enactment | 123 | HBAC to recommend initial benefit standards to Secretary. |
| 1 year after enactment | 163 | Secretary to issue a final rule on the HIPAA health claims attachment transaction standard. The standard would apply to electronic transactions occurring on or after a date beginning 6 months after enactment. |
| 1/1/2011 | 161 | Effective date of requirements on insurers in the group and individual markets to meet a minimum "medical loss ratio" (that is, the percentage of total premium revenue spent on medical claims, as opposed to administration or profit). |
| 18 months after enactment | 113 | Commissioner to submit to Congress a report on the private large-group health insurance market and on self-insured health benefit plans. |
| 18 months after enactment | 124 | Secretary to adopt HBAC recommendations or alternative standards. |
| 18 months after enactment | 152 | Secretary to promulgate regulations to prohibit discrimination in health care. Specifically, except as otherwise permitted by H.R. 3200, "all health care and related services ... covered by this Act shall be provided without regard to personal characteristics extraneous to the provision of high quality health care or related services." |

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